BRITISH COLUMBIA

Ref #: 244732
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Director in 2019

Circumstances of the Fatality

The review examined the case files of a youth who died from an accidental injury. The director was providing services to the youth and their family prior to the youth's death.

Findings

The youth had specific needs and parenting concerns were not addressed. The director did not respond to child protection reports and did not view the youth's home, meet with the youth, or coordinate information from other sources. Consultation to guide practice was not consistent and tools used to guide decision making were either not completed or inaccurately completed.

Actions

The involved Service Delivery Area (SDA) leadership and the Quality Assurance team developed an action plan to review the Child Protection Response Policies related to concluding a child protection response with the involved staff. This included a focus on the importance of completing interviews, home visits, collateral information gathering, consultation points, and Structured Decision Making tools. The SDA leadership also led a review of the Good Recording Guide with the involved staff.

The review was completed in October 2020. The above action plan was fully implemented in November 2020.